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Women's Sexual and Reproductive Health in the Arizona-Sonora Region

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Abstract

The purpose of this study is to determine whether health advocates are addressing and providing women's sexual and reproductive health programs in the Arizona-Sonora border communities in order to see if they have achieved the sexual and reproductive health goals set by the 1994 Cairo Consensus. The problem is recognized as the lack of reproductive health awareness among poor Hispanic/Latina and Native-American women within the Arizona-Sonora region. Telephone calls were made and a questionnaire of eight questions was posed in order to obtain information about sexual and reproductive health (SRH) programs and the services they render. This was done to analyze and see if the sexual and reproductive services offered in this region were working towards the sexual and reproductive health goals set by the 1994 Cairo Consensus.

Introduction

Women's sexual and reproductive health is becoming more of a public health priority in today's world. Due to international conferences such as the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt (also known as the Cairo consensus) and The United Nations Fourth World Conference on Women (FWCW) in Beijing, China in 1995, world leaders are calling on all countries to become more responsive in addressing issues surrounding sexual and reproductive health. Such issues include empowering women and providing them with more choices through extended access to education and health services and acknowledging and respecting their reproductive health and rights.

Consequently, in 1999 the United Nations did an assessment on the 1994 ICPD to determine what has been achieved by way of implementing the recommendations of the

ICPD. This process was known as Cairo +5 because it was an evaluation done five years after the Cairo consensus. Similar to the five-year assessment of the Cairo consensus, the FWCW also went through a review progress in the implementation proposed in Beijing, known as the Beijing +5. As a result of both these review sessions, it was found that human rights of women had gained recognition, violence against women was now an illegal act in almost every country, and there had been worldwide mobilization against harmful traditional practices; however, it was noted that much still needed to be done. This includes tackling new challenges such as the spread of HIV/AIDS in women, the need for primary health care in reproductive care and the unmet need for contraception. Women also must have more choices and be able to provide better nutrition, health care, and education for their children.

In recognition of the need for an international commission to address border health problems on the home front, the United States Congress passed a public law in October 1994, shortly after the Cairo consensus. This law allowed the president of the United States to arrive at an agreement with Mexico to create a binational commission, later known as the U.S.-Mexico Border Health Commission. It was formed to address the unique and severe health problems of the border region.

Increasing concern in sexual and reproductive health is steering toward the largest minority group in the United States currently: Hispanics/Latinos. Hispanic/Latina women, specifically along the U.S.-Mexico border, are known to be less likely to receive proper reproductive health care because of significant barriers, such as lacking access to health coverage and basic health information. Binational services working with communities along the border area, such as the U.S. Mexico-Border Health Commission

and Healthy Border 2010/Healthy Gente (Gente in Spanish means people), were launched to assure access to primary care, and basic health care services are provided for all. With regard to women's sexual and reproductive health, these programs aim to reduce infant mortality, teenage pregnancy rates, and the incidence of HIV/AIDS while improving prenatal care among low-income women within the U.S.-Mexico Border.

Health advocates, particularly in the Arizona-Sonora region, which is a portion of the total U.S.-Mexico border, have found it necessary to address issues concerning sexual and reproductive health, including access to primary health services for women. These services mainly aid the Native-American and Hispanic/Latina women residing in this area who are of low socio-economic status. Unfortunately, many of these women lack awareness of sexual and reproductive health services available to them, do not want to use the services, and/or do not have the financial means to take advantage of such services. This paper serves to analyze if health advocates are addressing the latter issues and providing sexual and reproductive health programs in the Arizona-Sonora border communities in order to see if they have achieved the sexual and reproductive health goals set by the ICPD.

Research Question

Have sexual and reproductive health services in the Arizona-Sonora region achieved the goals set by the 1994 ICPD?

Hypothesis

Although health advocates are making the efforts to provide sexual and reproductive health services to the women in the Arizona-Sonora region, the sexual and reproductive health goals set by the ICPD have not yet been reached. These goals are:

preventing unintended pregnancies, improving maternal health, and preventing, diagnosing and treating sexually transmitted infections (STIs), including HIV/AIDS. Each goal in itself is a secondary hypothesis and will be looked at on an individual basis.

Limitations

The span of ten weeks of the summer research program placed a limit on the amount of research that can be done with regard to locating all sexual and reproductive health services within the Arizona-Sonora region and surveying them. As a result of this, there was not a large enough sample size to do a thorough analysis on sexual and reproductive health services benefiting the majority of women residing within the Arizona-Sonora region. Another limitation was the inactivated telephone numbers of sexual and reproductive health services provided by the Arizona-Sonora Health Resources Guide. This too affected why there was not a large sampling size for the research project.

As for the health programs that were contacted, many did not have documented statistics readily available on the amount of women served since the program first started. This was needed to measure the quality of care of services received by these women. Vital statistics of women within the Sonora region in Mexico were not easily accessible as those provided by the Arizona Department of Health and therefore, a rough comparison using some statistics had to be made.

Literature Review

Some women's health is regularly compromised because their human rights are unfortunately disregarded. As a result of this, the United Nations supported the use of human rights as a means to improve women's reproductive health by sponsoring

conferences, primarily the 1994 International Conference on Population and Development, held in Cairo, Egypt and the 1995 Fourth World Conference on Women, held in Beijing, China. Both these conferences put in motion a worldwide effort to acknowledge and respect women's reproductive rights and develop programs to promote and protect these rights, with regard to women's sexual and reproductive health.

This literature review is mainly concerned with addressing issues surrounding women's sexual and reproductive health, which includes empowering women, providing them with more choices through extended access to education and health services, and acknowledging and respecting their reproductive health and rights. The need to address gender equality in health will also be discussed. And as a result of this, further research will launch a more analytical study on determining if health advocates within the Arizona-Sonora region are working toward addressing and resolving such issues.

Safeguarding and Promoting Women's Sexual and Reproductive Health

According to research done by Potts, Walsh, McAninch, Mizoguchi, and Wade, the ICPD recognized the goals of women's sexual and reproductive health (SRH) services in three components as family planning; prevention of sexually transmitted infections (STIs), including HIV/AIDS; and basic reproductive health services (other services needed to reduce maternal mortality – e.g., safe motherhood programs, abortion-related services, reproductive health education and communication, STIs diagnosis and treatment, and infertility prevention and treatment). [1] Thus, it is imperative for SRH programs to provide women adequate sexual and reproductive health care, or high rates of unwanted pregnancy, unsafe abortion and preventable death and injury will be the

[1] Potts, M., Walsh, J., McAninch, J. Mizoguchi, N., and Wade, T.J. (1999, January). Paying for Reproductive Health Care: What Is Needed, and What Is Available? *International Family Planning Perspective*, 25, S10-S16. Retrieved June 12, 2006 from JSTOR database.

unfortunate result. As mentioned by the United Nations Population Fund (UNFPA)[2], increased access to family planning is clearly the best way to reduce abortion, and care for women who have undergone abortion is also an important way to reduce maternal mortality.

With regard to SRH programs aiming to achieve the ICPD goal of reducing maternal mortality, Cook and Fathalla[3] investigated whether comprehensive reproductive health care, including contraceptive services and requested terminations of ill-timed or high-risk pregnancies, would promote safe motherhood. As a result of their research, it is important to understand that effective SRH programs should include components that work to diminish the rate of maternal deaths.

The right to an education is also particularly important for the promotion and protection of women's health, according to Cook and Fathalla[4]. Here, the ICPD goal of achieving reproductive health education and communication among women is the focus. Research has consistently shown that women's education strongly influences improved reproductive health, including infant survival and healthy growth of children.[5] Consequently, it can be said that the need for women to receive health education in sexual and reproductive health is beneficial to not only their health, but their child's, and SRH programs should include such an important element in the services they provide.

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[2] *Lives Together, Worlds Apart: Men and Women in a Time of Change.* (n.d.) United Nations Population Fund. Retrieved June 5, 2005 from http://www.unfpa.org/swp/2000/English/press_kit/summary.html.
[3] Cook, R.J., Fathalla, M.F. (1996, September). Advancing Reproductive Rights Beyond Cairo and Beijing. *International Family Planning Perspectives,* 22(3), 115-121. Retrieved June 12, 2006 from JSTOR database.
[4] Cook, R.J., Fathalla, M.F. (1996, September). Advancing Reproductive Rights Beyond Cairo and Beijing. *International Family Planning Perspectives,* 22(3), 115-121. Retrieved June 12, 2006 from JSTOR database.
[5] Hobcraft, J.N. (1993, October). Women's Education, Child Welfare, and Child Survival: A Review of the Evidence. *Health Transition Review,* 3(2), 159-173. http://eprints.anu.edu.au/archive/0000048/html.

Gender and Health

Women's health in general, and their sexual and reproductive health in particular, is determined not only by their access to health services, but by their status in society and pervasive gender discrimination.[6] Studies indicate that gender inequalities in access to health unfortunately affect women's well being.[7] It has also been understood that as a result of gender inequality harming women's health, gender health inequality prevents many women from participating fully in society.[8] By being affected by gender inequality in health, women are losing out on effective health programs and allowing not only their health, but also their interaction with the community to be jeopardized. Cohen speculated that the social benefits of women partaking in SRH programs are usually overlooked.[9] Cohen also asserts that women who participate in these health services will not only save their lives and their infant's, but will also prevent experiencing poor social and economic development.[10] Here it is important to note that SRH programs offering their services to women will permit women to become social participants within their communities and help accomplish the ICPD goal of empowering women through offering innovative health education communication programs within the community.

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[6] Shalev, C. (2000). Rights to Sexual and Reproductive Health – the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women. *Health and Human Rights.* 4(2), 36-66. http://www.un.or/women watch/daw/csw/shalev.html.

[7] Doyal, L. (2001). Sex, Gender, and Health: The Need For a New Approach. *BMJ*, 323, 1061-1063. http://www.bmj.com/cgi/content/full/323/7320/106/#BIBL.html.

[8] *Lives Together, Worlds Apart: Men and Women in a Time of Change.* (n.d.) United Nations Population Fund. Retrieved June 5, 2005 from http://www.unfpa.org/swp/2000/English/press_kit/summary.html.

[9] Cohen, S.A. (2004, March). The Broad Benefits of Investing in Sexual and Reproductive Health. *The Guttmacher Report on Public Policy*, 7(1), 5-8. Retrieved June 5, 2006 from Guttmacher Institute database.

[10] Cohen, S.A. (2004, March). The Broad Benefits of Investing in Sexual and Reproductive Health. *The Guttmacher Report on Public Policy*, 7(1), 5-8. Retrieved June 5, 2006 from Guttmacher Institute database.

Programs that address gender inequality and engage men from the community as partners in fighting diseases such as AIDS can help slow the spread of the disease.[11] It is safe to say that in order to hinder the spread of such diseases, gender sensitive reproductive programs are necessary to equalize gender inequality and protect women's health. By doing this, the ICPD goal of preventing the spread of STIs, including HIV/AIDS, will be achieved. It is also fair to mention that in order to improve access to health services for women, the need to examine the potential of wider social and economic policies for promoting gender equality in health must be considered.[12]

With regard to female empowerment, Cohen and Richards found family planning and reproductive health programs must be coordinated, from a policy and programmatic standpoint, with efforts in basic education and the empowerment of women.[13] These programs will therefore focus primarily on the ICPD goal that promotes health education and teaches women how to have power over their lives and health. This will also encourage women to be more willing to hold positions of authority in order to bring about change for the betterment of women, in health and politics.

U.S.-Mexico Binational Effort to Protect Women's Health

Hispanic/Latina sexual and reproductive health is crucial to the advancement of women's empowerment, human rights, and poverty alleviation. In recognition of this, the Health Group of the Binational Commission, which was created in 1996, identified four priorities for binational collaboration; women's health/reproductive health was one of

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[11] *Lives Together, Worlds Apart: Men and Women in a Time of Change.* (n.d.) United Nations Population Fund. Retrieved June 5, 2005 from http://www.unfpa.org/swp/2000/English/press_kit/summary.html.
[12] Doyal, L. (2001). Sex, Gender, and Health: The Need For a New Approach. *BMJ*, 323, 1061-1063. http://www.bmj.com/cgi/content/full/323/7320/106/#BIBL.html.
[13] Cohen, S.A,, Richards, C.L. (1994, November-December). The Cairo Consensus: Population, Development, and Women. *Family Planning Perspectives*, 26(6), 272-277. Retrieved June 12, 2006 from JSTOR database.

these four priorities. Border health advocates created the binational initiative known as the Project Consensus to identify border health priorities, which was funded by the U.S. federal government.[14] As a result, the project recognized the area of mother-child health (including specific topics such as prenatal care, family planning, and teen pregnancy) as a health concern felt and shared by communities on both sides of the border. These are also distinct goals the ICPD wanted for each country to accomplish, in terms of providing these services and help decrease high rates of teen pregnancy and abortions.

In both countries there are two distinct approaches to the concept of women's health: in Mexico the focus is on Maternal and Reproductive Health, while in the United States the model is defined as Women's Health.[15] For example, this can be seen in the Arizona-Sonora border region where the crossroads of two health care paradigms are evident: a socialized health care system in Mexico and a privatized one in the U.S. [16] This is because the Mexican medical system provides universal health coverage either for a nominal fee or free of charge. It is quite an integrated system of hospitals, rural clinics, private doctors, and outreach workers.

Hispanic/Latina Lack of Sexual and Reproductive Health Care Awareness

Reproductive health awareness is low among Hispanic/Latina immigrants regardless of sexual experience or age. Studies have demonstrated that the lack of reproductive health knowledge is primarily due to a combination of low educational

[14] Apodaca, B., Mendoza, G. (2002). Women's Health/Reproductive Health on the U.S.-Mexico Border, Retrieved June 5, 2006 from Pan American Health Organization website: http://sandiegohealth.org//border/index.html.
[15] Apodaca, B., Mendoza, G. (2002). Women's Health/Reproductive Health on the U.S.-Mexico Border, Retrieved June 5, 2006 from Pan American Health Organization website: http://sandiegohealth.org//border/index.html.
[16] Pope, C. (2001). Babies and Borderlands: Factors That Influence Sonoran Women's Decisions to Seek Prenatal Care in Southern Arizona. In I. Dyck, N. Davis Lewis, and S. McLafferty (Eds.), *Geographies of Women's Health* (pp. 143-158). New York, NY: Taylor & Francis Group.

attainment and lack of sexual education among Hispanic/Latina immigrants.[17] Hence, it is clear that sexual and reproductive health education, information and services are necessary for these Hispanic/Latina immigrants.

With regard to STIs, including HIV/AIDS, immigrants are perceived to be at greater risks for HIV due to lack of accurate HIV information, language barriers, and less use of health services due to fears of deportation.[18] Many Hispanic women perceive HIV/AIDS as a low priority problem in comparison with other problems they have, such as poverty, unemployment, poor health, lack of access to adequate health care and health insurance, undocumented status, and educational disadvantages.[19] Their perception of being at risk may be due to their lack of knowledge.

The educational level of Hispanic women is lower than that of Anglos, with Mexican-American's having the lowest level of all Hispanic groups.[20] The need for materials designed specifically for young girls in this ethnic group is apparent in order to help educate them not only about their bodies, but about the health risks that may be a result of poor sexual behavior decisions. Hispanics adolescent girls have been found to be less knowledgeable about HIV/AIDS than Whites.[21] Therefore, it can be said that although education does not guarantee absolute behavioral change, the need to have these women aware of the risks that will lead to contracting HIV/AIDS is necessary in order

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[17] Foulkes, R., Donoso, R., Frederick, B., Frost, J.J., Singh, S. (2005). Opportunities for Action: Addressing Latina Sexual and Reproductive Health. *Perspectives on Sexual and Reproductive Health*, 37, 39-44. Retrieved on June 5, 2005 from Guttmacher Institute database.

[18] California Research Project (1994): *Health Risks Among Immigrant Population.* Sacramento, California Research Project.

[19] Centers for Disease Control and Prevention (1986). Acquired Immune Deficiency Syndrome (AIDS) among blacks and Hispanics, United States. *MMWR*, 35 (655-666). http://www.cdc.gov/mmwr/preview/mmwrhtml/00000810.html.

[20] Gallegos, G. (1995). Sex and Death: Issues Affecting Cultural and Sexual Behavior of Latina Women in the Era of AIDS. Proceedings on U.S.-Mexico 1995 Border Conference on Women's Health, 1, 101-107.

[21] Rogers, M.F., Williams, W. (1987) AIDS in Blacks and Hispanics: Implications for Prevention. *Issues in Science Technology*, 3, 88-94.

for them to make some change in their lives. Identifying these problems will therefore set in motion the quest of making improvements and reaching the goals set by the ICPD.

Hispanic/Latina Women and Prenatal Care

Prenatal care is an important reproductive health care service that helps ensure women have healthy pregnancies. In particular, prenatal care allows for monitoring of pregnancy complications, for example low fetal birth weight. The lack of prenatal care has been proven to be a risk factor for low birth weight.[22] Effective prenatal care has important benefits beyond monitoring fetal low birth weight that can improve the health of Hispanic/Latina immigrants. Although a low prevalence of low birth weight has been observed in Hispanics/Latinas, particularly Mexican-Americans compared with whites and blacks, there is still a low use of prenatal care services reported for this group.[23]

And according to the National Latina Institute for Reproductive Health, identifying diseases such as TB (tuberculosis), chlamydia and HIV through prenatal care services can save the life of the mother and her baby and also reduce the risk of maternal mortality, which is relatively high among Hispanics/Latinas.[24] Therefore, it is safe to conclude that Hispanic/Latina women need prenatal care so that early detection of disease, pregnancy complication and treatment can be administered to as soon as possible.

Studies done by the Centers of Disease Control and Prevention found women who receive delayed or no prenatal care or who do not receive timely preventive care or

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[22] Balcazar, H., Aoyama, C. (1991, July-August). Interpretative Views on Hispanics' Perinatal Problems of Low Birth Weight and Prenatal Care. *Public Health Reports*, 106, 420-426. Retrieved on July 18, 2006 from LexisNexis database.

[23] Balcazar, H., Aoyama, C. (1991, July-August). Interpretative Views on Hispanics' Perinatal Problems of Low Birth Weight and Prenatal Care. *Public Health Reports*, 106, 420-426. Retrieved on July 18, 2006 from LexisNexis database.

[24] National Latina Institute of Reproductive Health (2005, December). The Reproductive Health of Latina Immigrants. Retrieved June 9, 2005, from http://latinainstitute.org/pdf/RepoHlthImgrnt-5.pdf.

education, are at risk for having undetected complications of pregnancy.[25] This can result in severe maternal and/or fetal morbidity and sometimes death. Consequently, women who do not take advantage of prenatal care services are allowing unobserved pregnancy problems to become bigger problems and potentially endangering not only their lives, but their baby's also. Among Hispanics/Latinas women, studies show a higher percentage of women who initiated prenatal care in the third trimester or had no prenatal care.[26]

It has also been proven that undocumented immigrants are less likely than legal immigrants to have had prenatal care or care before the third trimester, to return for postpartum examinations for themselves, to seek neonatal care for their infants, or to have had Pap smears.[27] In support of this, Balcazar and Aoyama suggest that Mexican-born women in the United States under utilize available health facilities and are at a greater risk of not receiving prenatal care.[28] For this reason, much needs to be done to make these women realize the importance of utilizing sexual and reproductive health services, especially prenatal care in order to decrease the risk of a complicating pregnancy and achieve the goals set by the Cairo Consensus.

Literature Review Conclusion

The potential for abuse of [reproductive] rights is often greater among women from minority and low-income communities, indicating that great care must be applied in

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[25] Anachebe, N.F., Sutton, M.Y. (2003, April). Racial Disparities in Reproductive Health Outcomes. *American Journal of Obstetrics and Gynecology*, 188(4), S37-S42. Retrieved July 9, 2006 from Science Direct database.

[26] Balcazar, H., Aoyama, C. (1991, July-August). Interpretative Views on Hispanics' Perinatal Problems of Low Birth Weight and Prenatal Care. *Public Health Reports*, 106, 420-426. Retrieved on July 18, 2006 from LexisNexis database.

[27] Gany, F., De Bocanegra, H.T. (1996, August-October). Overcoming Barriers to Improving the Health of Immigrant Women. *Journal of the American Medical Women's Association*, 51, 155-160. Retrieved on July 20, 2006 from http://www.hawaii.edu//hivandaids/Overcoming%20Barriers%20to%20 Improving%20%the%20 Health%20of %20Immigrants%20Women.pdf

[28] Balcazar, H., Aoyama, C. (1991, July-August). Interpretative Views on Hispanics' Perinatal Problems of Low Birth Weight and Prenatal Care. *Public Health Reports*, 106, 420-426. Retrieved on July 18, 2006 from LexisNexis database.

delivering family planning services in such communities.[29] With this statement I believe my study fits in the research field of women's sexual and reproductive health because health advocates within the Arizona-Sonora region find it necessary to address issues concerning the reproductive rights of the poor women population utilizing sexual and reproductive health services. This includes access to primary SRH programs. These services mainly aid the low income Native-Americans and Hispanic/Latina women residing in this area. It is with this study that I intend to examine whether health advocates in the Arizona-Sonora border have achieved the sexual and reproductive health goals set by the ICPD.

Methodology:

Research Variables

In this study the independent variables were the Hispanic/Latina and Native-American women of reproductive age, which is 15-44, while the dependent variables were the sexual and reproductive services from each sexual and reproductive health program surveyed.

Research Design

This research study is an action based and case and field research study. It is action based research because applied research is focused on finding a solution to a local problem in a local setting. For this research study, the problem is recognized as the lack of reproductive health awareness between poor Hispanic/Latina and Native-American women within the Arizona-Sonora region. This research project is also a case and field research study because data were gathered from sexual and reproductive health facilities

[29] Cook, R.J., Fathalla, M.F. (1996, September). Advancing Reproductive Rights Beyond Cairo and Beijing. *International Family Planning Perspectives*, 22(3), 115-121. Retrieved June 12, 2006 from JSTOR database.

within the Arizona-Sonora region through the use of surveys for the purpose of studying interactions and characteristics of the health programs they offer.

Sampling

Involved in this study were eight sexual and reproductive health facilities located within the border region of Arizona and Sonora. More facilities were anticipated, but due to time constraints and the response of contacted facilities, eight ended up being the total sample size. Five of these facilities were from the four southern counties of Arizona: Yuma County, Pima County, Santa Cruz County and Cochise County, whereas three were from Sonora, México. These facilities must render services to women of reproductive age (15-44).

Data Collection Methods

Telephone numbers of sexual and reproductive health services within the Arizona-Sonora region were found through the Arizona-Sonora Health Resource Guide telephone directory. Telephone calls were made and a questionnaire of eight questions was posed in order to obtain information about SRH programs and the services they render.

Data Analysis

After acquiring responses from the eight SRH programs, all were gathered and compared to each other by services provided from each country. The information obtained includes when the program first began, a description of the sexual and reproductive services provided to women of reproductive age, if services are rendered primarily to women of reproductive age, and if the program frequently provides services to women who cross the border. The data also collected show if women have difficulty

accessing the facilities that provide the SRH programs and if yes, then why, if primary care and preventive services are well equipped with sufficient amount of supplies and materials needed to help run programs, and if services improved the health of the number of women who utilized these services from when the program first began compared to now. Secondary source data were also used to compare the rates of teen pregnancies and prenatal care of women from each county in Arizona and within the border of Sonora.

Results and Findings

Through the binational Arizona-Sonora Health Resources Guide, health objectives were outlined in order to meet the goals of Healthy Border 2010/ Healthy Gente. Table 1 gives an overview of the efforts health advocates are making from each county to provide services, including sexual and reproductive services, so that improvement in health for all is achieved. It can be said from the table that health facilities from Santa Cruz are currently providing the largest percentage of women's health services (includes primary care services and health screening for cancer or other life-threatening disease) among all the other border counties, at 48%. It can therefore be concluded that almost half its health services are geared toward the improvement of women's health along the Arizona-Sonora region. Another observation made is that both Cochise and Pima Counties provide the same percentage (32%) of health care facilities working towards to improve women's health and accomplish the goals set by the ICPD.

As for the percentage of health facilities addressing maternal and child health issues, Pima County showed the highest percentage of all counties at 54%. This means that over half the services in which are provided for in Pima County concentrate on the advancement of better health outcomes for women residing along the Arizona-Sonora

border. At 41%, health facilities in both Cochise and Santa Cruz Counties have equal facilities that are working to recognize and reduce the amount of health problems concerning maternal and child health, which includes maternal mortality, low birth weight infant, and increasing awareness of access to prenatal care within the first trimester of pregnancy.

Table 1. The Number and Percentage of Health Facilities Borderwide within the Southern Arizona Counties Working Towards the Healthy Border 2010/ Healthy Gente Goals

N/A: Not Applicable. Information was not given.
Statistics from Arizona-Sonora Health Resources Guide: http://www.borderhealth.net/pdf/english.pdf

County	Total Number of Programs	Percentage working toward Access to Care	Percentage working toward Maternal Health	Percentage working toward HIV/AIDS	Percentage addressing Maternal & Child Health	Percentage addressing Women's Health	Percentage addressing Adolescent Health	Percentage addressing Health Education/ Promotion
Cochise	49	25%	N/A	8%	41%	32%	64%	57%
Pima	83	26.5%	18%	N/A	54%	32%	31%	66%
Santa Cruz	45	15%	3%	8%	41%	48%	63%	89%
Yuma	69	37%	10%	N/A	18%	28%	21%	60%

Table 2 and 3 were constructed based on the information given over the phone at the time of surveying the health facilities within the Arizona-Sonora region. A total of

five facilities that provided sexual and reproductive health services were surveyed from the southern counties of Arizona (Cochise, Pima, Santa Cruz, and Yuma Counties), which border one of Mexico's northern states: Sonora. A total of three health facilities were questioned from the border cities Agua Prieta, Nogales, and San Luis Rio Colorado in Sonora, Mexico. Information such as telephone numbers and a brief description on the types of sexual and reproductive health services were located in the Arizona-Sonora Health Resources Guide in order to help distinguish which services to contact.

Table 2 shows that two of the five health facilities surveyed were from Yuma County (Border Health Foundation – Puentes de Amistad and Yuma Department of Public Health). It should be noted that sexual and reproductive health services are supported and funded by both Yuma and Cochise Health Departments but, the actual facilities providing said services are throughout the border region. It can also be seen in table 2 that the Carondelet Health Network has health facilities in both Santa Cruz and Pima Counties where women can receive sexual and reproductive health services.

Of the six sexual and reproductive health services reported by the health facilities, four of the five health facilities provide prenatal care, three provide family planning, two render services toward gynecological care, three offer HIV/AIDS prevention and health education, and two provide teen pregnancy services. When comparing the number of services provided by health facilities, Cochise Health Department offers all but one of the six sexual and reproductive health services, and health facilities under the Yuma Department of Public Health provide a total of four out of the six services the ICPD goals are said to accomplish.

Table 2. **Surveyed Facilities Providing Sexual and Reproductive Health in Arizona Border Counties**

*Primary Care Services
**Preventive Services
X-Indicates the services provided by facility

Name of SRH Facilities			Sexual and Reproductive Health Services Offered					
	5 SRH facilities in AZ surveyed	AZ Border Counties	Prenatal Care*	Family Planning	Gynecological care* (screening for breast and cervical cancer)	HIV/AIDS Prevention (testing), Counseling, and/or Treatment**	Health Education	Teen Pregnancy (Pregnancy Testing, Contraception Distribution)
A								
R	El Pueblo Clinic, Inc.	Pima	X	X	X		X	
I	Border Health Foundation-Puentes de Amistad	Yuma				X		
Z								
O	Carondelet Health Network	Santa Cruz, Pima	X	X	X			
N								
A	Cochise Health Department	Cochise	X	X		X	X	X
	Yuma Department of Public Health	Yuma	X			X	X	X

The results from Table 3 illustrate that all health facilities contacted in Sonora provide both prenatal care and teen pregnancy services. This is a very important observation, considering that these are the services which are mentioned by the ICPD as being very important aspects in improving and advancing women's sexual and reproductive health throughout the world. Other results show that two health facilities provide family planning and gynecological care, whereas only one of the facilities contacted offer HIV/AIDS prevention and only one renders health education services.

From this table, one can conclude efforts are being made to reach the goals set by the ICPD, in terms of having these services available to women of the surrounding to meet their sexual and reproductive health needs.

With regard to the other questions posed, many of these facilities generally reported similar answers. An interesting observation is that all the facilities do not document nor ask patients if they are from Arizona or Mexico. They all commented that they are here to serve anyone who walks through their doors. The majority however, felt that their facility is not equipped with sufficient amount of supplies, especially facilities in Arizona, because funding continues to be cut by the federal government. Only two out of the eight surveyed facilities said that patients have difficulty accessing the facility because one moved to a farther location and the other believed women found other services to go to instead of theirs. In regard to the facility that switched locations, they are in the process of making transportation arrangements for the patients they serve so it will allow patients to keep up with appointments and continue accessing health care needs. The sampling size was small, but it obvious that these facilities are in the community attempting to inform women about utilizing these services for the betterment of their health.

Table 3. Surveyed Facilities Providing Sexual and Reproductive Health in Sonora, Mexico Border Cities

*Primary Care Services
**Preventive Services
X-Indicates the services provided by facility

Name of SRH Facilities			Sexual and Reproductive Health Services Offered					
S O N O R A	3 SRH facilities in Sonora surveyed	Mexico Border Sister Cities	Pre-natal Care *	Family Planning	Gynecolo-gical care* (screening for breast & cervical cancer)	HIV/AIDS Prevention (testing), Counseling, and/or Treatment**	Health Education	Teen Pregnancy (Pregnancy Testing, Contraception Distribution)
	Hospital General de Agua Prieta Salud Reproductiva	Agua Prieta	X	X	X			X
	General de Nogales Salud Reproductiva	Nogales	X	X	X			X
	Sexualidad en la Adolescenia/ Embarazo en la Adolescenia	San Luis Rio Colorado	X			X	X	X

Generally, the information found during this study showed that health advocates providing sexual and reproductive health services within the Arizona-Sonora region are working towards achieving the sexual and reproductive health goals set by the ICPD. They are doing so by identifying sexual and reproductive health services within the Arizona-Sonora region through the creation of the Arizona-Sonora Health Resources Guide and attempting to keep a record of the amount of facilities offering such services. Supplemental data are also provided by the Arizona Department of Health Services vital statistics and the report of Salud Reproductiva en Sonora: Perfil Epidemiológico Y Retos

Para Su Atención[30] in order to present further information on the health status of the women residing in the Arizona-Sonora region.

According to the Arizona Department of Health Services, in 2003 Hispanics/Latinos ranked worse than average in poor utilization of early prenatal care, high teen pregnancy rates and high premature mortality. [31] Particularly by county, Yuma had 58.2% of women receive prenatal care in the first trimester, followed by Santa Cruz County at 64.6%, and Pima and Cochise County at 69.4% and 69.8%, respectively.[32] With regard to improving sexual behavior, Arizona's vital statistics illustrate the need to reduce teen pregnancy among adolescent females ages 15-17 in order to meet the national objective of 25% by the year 2010.[33] In the border counties, statistics demonstrate that much more health education and sexual and reproductive awareness among adolescent females is needed in order to help decrease the percentage of females getting pregnant and acquiring STIs at such young ages. The goal is to reduce pregnancies among this age group by 25%; currently, Yuma County is at 56.3%, Santa Cruz at 46.1%, Pima at 39.3 percent and Cochise at 34.4%.[34]

[30] Translated as Reproductive Health in Sonora: Attention to Epidemiological Profile and Challenges
[31] Arizona Department of Health Services (2003). Differences in the Health Status among Ethnic Groups, Arizona. http://azdhs.gov/plan/report/dhsag/dhsag03/ethnic03.pdf
[32] Arizona Department of Health Services Vital Statistics (2004) Monitoring Progress Toward Arizona and Selected National Year 2010 Objectives: 2004 County Profiles. http://azdhs.gov/plan/report/ahs/ahs2004/pdf/6b.pdf
[33] Arizona Department of Health Services Vital Statistics (2004) Monitoring Progress Toward Arizona and Selected National Year 2010 Objectives: 2004 County Profiles. http://azdhs.gov/plan/report/ahs/ahs2004/pdf/6b.pdf
[34] Arizona Department of Health Services Vital Statistics (2004) Monitoring Progress Toward Arizona and Selected National Year 2010 Objectives: 2004 County Profiles.

American Indians in Arizona have a high incidence of birth defects and high infant mortality.[35] It is important to note that due to time constraints and no response from health facilities providing sexual and reproductive health services to American Indians within the Arizona-Sonora region, the reason for high incidence of birth defects and high infant mortality can only be assumed as the women of the Tohono O'odham and Pascua Yaqui tribe are not obtaining prenatal care within the first trimester of pregnancy. As demonstrated by the Arizona health status and vital statistics of 2004, the current percentage of American Indian women receiving prenatal care in the first trimester of pregnancy is 69%, compared to 54.9% back in 1994.[36] The national objective is to increase this percentage to 90 percent by the year 2010. Therefore, health advocates in Arizona must continue to help American Indian women become aware of the importance of prenatal care within the first trimester of pregnancy. In doing so, the goals set by the ICPD of providing such services will be achieved.

In Sonora the vital statistics used for this study was the report known as the Salud Reproductiva en Sonora, 1990-2000: Perfil Epidemiológico Y Retos Para Su Atención. These statistics found that there was a significant increase in the use of sexual and reproductive health services offering family planning because during the 1990s, more attention was placed on women's sexual and reproductive health and their well being in Sonora. For example, in 1992, the percent of women using contraception was 52.7%; in 1997 the percentage increased to 67.5% and it was estimated that in 2000, the percentage

[35] Arizona Department of Health Services Vital Statistics (2003). Differences in the Health Status among Ethnic Groups, Arizona. http://azdhs.gov/plan/report/dhsag/dhsag03/ethnic03.pdf
[36] Arizona Department of Health Services Vital Statistics (2004). Health Status Profile of American Indians in Arizona, 2004 Date Book. http://azdhs.gov/plan/report/hspam/indian04.pdf

was up to 70.8%.[37] As a result of the increase in utilization of contraception, Sonora placed 4th nationally among all the other states in Mexico. Furthermore, it can be concluded that with the recognition of the importance of women's sexual and reproductive health during the 1990s, especially after the Cairo Consensus, health advocates in Sonora have begun promoting health objectives among women in order to reach the set goals of the ICPD.

Prenatal care primarily focuses on efficiently preparing women for a healthy pregnancy by keeping a constant watch on their health so that complications that may occur will be detected early enough to prevent maternal and infant mortality. In Sonora, prenatal care primarily focuses on reducing infant mortality. According to the Salud Reproductiva en Sonora report, from 1974-1976, one in three women never received prenatal care; however, between the years 1994-1997, the numbers changed to one in every thirteen women never receiving prenatal care.[38] It is also vital to see that by 1997, the national percentage of women who visited a physician in Mexico during the first trimester of pregnancy was 86.6%, whereas in Sonora alone it was 84.5%.

Conversely, it is also important to mention that although overall 32.4% of women residing along the border received prenatal care in the first trimester of pregnancy in 1998, the statistics for the whole state of Sonora was 33% and this percentage was still below the percentages of the other five states along the U.S.-Mexico border.[39] Thus, from the information stated, health advocates have made advances toward identifying and promoting women's sexual and reproductive health by having services along the

[37] Salud Reproductiva en Sonora, 1990-2000: Perfil Epidemiológico Y Retos Para Su Atención. pp. 20-25
[38] Salud Reproductiva en Sonora, 1990-2000: Perfil Epidemiológico Y Retos Para Su Atención. pp. 20-45.
[39] Salud Reproductiva en Sonora, 1990-2000: Perfil Epidemiológico Y Retos Para Su Atención. pp. 20-45.

Arizona-Sonora border, but improvements continuously need to be made in order to reach the goals of providing prenatal care to the majority of women living within this border region.

Conclusion

Throughout this research study, the importance of safeguarding women's sexual and reproductive health has been illustrated. Along with protecting the life of mother and child during prenatal care, reducing the rate of adolescent females getting pregnant and providing preventive services for STIs, including HIV/AIDS, comes the most significant reason to encourage women's sexual and reproductive health along the border: to promote and emphasize the importance of women's sexual and reproductive health awareness. Numerous women are not taking advantage of these services that help them take control of their health and be responsible about the choices they can make with regard to their health, mainly because they are not aware of what services are out in the community and the importance of utilizing such services.

Health advocates are continuing to strive for the ICPD sexual and reproductive health goals by making the first attempt in having sexual and reproductive health services available to women along the Arizona-Sonora region, but they will need to find more innovative ways to attract these women to these services, which they will benefit from. Further study will be needed to measure the quality of care these services provided in order to fully show that the sexual and reproductive health goals set by the Cairo consensus have not yet been reached.

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